Meaningful Use Workgroup
Subgroup #3: Improving Care Coordination
Draft Transcript
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Presentation

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #3 Improving Care Coordination. This a public call and there will be time for public comment at the end and the call is also being transcribed so please make sure you identify yourself before speaking. I'll now take roll. Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Michael Barr? Jessica Kahn? David Bates? George Hripcsak? Eva Powell? Leslie Kelly Hall? Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Larry. Are there any staff on the line?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Mary Jo Deering, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Mary Jo.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle.

Emma Potter – Office of the National Coordinator

Emma Potter, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Emma. And are there any other Meaningful Use Workgroup members on the line? Okay, with that Charlene, I'll turn it over to you.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Thank you, MacKenzie and Michelle. The purpose of today's call is to review feedback from the HIT Policy Committee and the Meaningful Use Workgroup relative to our recommendations and to start I actually wanted to review the principle slide again that you'll find in the deck, if you can bring that up and we wanted just to re-enforce one of those principles or these principles that were in the slide.

Again, these are not new information, we designed our recommendations with these fully in mind in terms of supporting the new models of care, addressing the national health priorities, and again, I understand, certainly Farzad in terms of the Million Hearts Campaign, NQF again is now starting to link, and I think this is great, our initiatives to some of the National Quality Initiatives and again, we continue to need to be sensitive to that.

Broad applicability, and again this is something where meaningful use is considered a floor and whereas perhaps in the earlier stages of meaningful use it was perhaps more primary care centric, in Stage 2 we worked really hard to increase the applicability of meaningful use and it's critical that in Stage 3 that we continue to increase the applicability of what our requirements are, especially as we look at specialty care and especially as we look at the problem that we're trying to solve, because, again patients, especially those who are requiring a large amount of care, and Larry can see this, you know, say 6-8, you know, to 10 different care doctors in all specialties, patient health needs, certainly as part of that, as well as the recognition of reflecting the propensity of IT, as well the propensity of care across different areas of our country. So, those are kind of challenging objective, but we need to be sensitive to those.

We want to promote advancement, so we need to be sensitive to if it's an area that the market will drive either because of health care reform initiatives or what the market needs to do to respond to things or the fact that for instance mobile health is, you know, a new factor in the field, those things we can be a little lighter on, but those things where we don't see the market driving us are things where we need to be able to apply some leverage.

Achievable, and again, this is I think probably a challenging one, because we're thinking out 2016, we don't know what can be accomplished in 2014. All of us are hoping that it's got to be a lot, so there is a tension between what's mature today and what might become more mature by 2016 and we listened to the feedback from Neil Calman relative to on one hand we certainly want something that's deployable, but on the other hand we don't want standards to be the enemy of good, and at this point for Stage 3 we want to push the window a little bit. So, again, we need to, again make that a first principle, but we also have to try and identify where we think that we want to really advance the initiatives.

And lastly on this one was added in, the reasonableness and feasibility of products and/or organizational committee, and again, part of our workgroup's charge is maybe not to know all that information and I have to admit to that, I did do some chatting with some of the vendors, but again, you know, they don't even know what Stage 2 is yet, so it's hard to really know what Stage 3 might look like.

And the other important part is organizational capacity and ability to be able to adopt such a change. I think we have to be particularly sensitive to that, because some of these really rely on pretty significant process change and I think that last point kind of comes back, we don't want standards to be an excuse for not moving forward, but again, where they are missing and we feel they are urgent we certainly have to, you know, press forward and really advocate for them, that's part of what our role is.

Are there any other points or themes that others on the call want to add in? And, Larry I know you were on…

John Halamka, MD, MS – Harvard Medical School

This is John Halamka, Charlene, so I'm here if you have any standards related questions.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Perfect and your timing is great, so, as we walk through the details of our recommendations we had asked maybe that…you'd given us some feedback but maybe you could reflect on that last point, because I think that was a pretty significant point of feedback from the Policy Committee and having you here on the call we really appreciate.

John Halamka, MD, MS – Harvard Medical School

Well, sure, and so recognize that the standards for things like care plans are very much an evolution, that you see in the consolidated CDA effort of the S&I Framework a text-based care plan that is going to be sufficient for a very basic follow-on set of instructions. However, we recognize that…yes?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We've actually got these an objective, so could I ask if I go through each one you give us your commentary, because we'll touch on those and then we can capture it and make our changes, would that work for you?

John Halamka, MD, MS – Harvard Medical School

Absolutely.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, Larry or Michelle or MacKenzie did you have anything else to add on the principles?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think that this whole attempt to drive things off of principles is really good and we probably actually should do this explicitly as we go through each one, if we can take the time to just, you know, to check the bullet items, because I know these are our intentions, but it would be good to sort of just do a quick check as we go through that we're actually on track with these.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

A quick check.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, Michelle, what you can do since I don't have multiple pieces in front, you can just like, you know, we'll discuss the topic and then maybe we close with just nodding through each of them and just make sure we check them off or something. Would that work?

Michelle Nelson – Office of the National Coordinator

Sure.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, next slide. So, our first objective again was advancement of…and John I know you gave us some…advancement of the reconciliation capability and as a broad scope kind of what I wanted to bring up and you may not have heard, is our group really looked at 3 major areas of advancement in care collaboration, one of those being, and we made some assumptions that standard and exchange would be further deployed in Stage 2, one of them is certainly communication. A second piece of that was tracking and a third piece of that was reconciliation, and we endorsed and are trying to move toward a more robust reconciliation function in Stage 3 assuming that there is going to be more exchange.

So, what we asked for in Stage 3 is we recognize today…we continue to advance the need for medication reconciliation, we understand it's difficult, we hear a lot of feedback relative to when things…who is going to own the reconciliation between specialist and primary care providers, for instance who really owns managing blood pressure, those kinds of things. So, there is a lot of pieces that yet still have to be sorted out in that area, but we also endorse for Stage 3 the reconciliation around medication allergies, and we're also advancing the need for reconciliation around problems, and again the logic there is that we feel it's really important as the basis of care planning and managing patients around their needs to start to share problems.

And we understand the challenges of their potentially different problem list and that type of thing, but, and that's something where I think where we are going to need more guidance and direction, so that's the logic and that's what we would like to advance. We spent a lot of time discussing the potential to reconcile contraindications and these again are cases where there is potential orders or potential interventions that put the patient at risk that we also want to check for, but we felt at this point in time that those could potentially be problems and it gets confusing between what those two scenarios are, so it was a piece that we put out there as a stakeholder for Stage 4 so there can be some more thought about those kinds of…you know, how to identify those kinds of issues.

So, I know you gave us some feedback in one of the earlier documents relative to medications and allergies, but we would appreciate, you know, your thought in this one, again, there were no changes suggested, but again, I think to ensure its viability and those other requirements we certainly welcome your input here.

John Halamka, MD, MS – Harvard Medical School

Well, I'll tell you just in general yesterday the HIT Standards Committee approved a framework for assessing standards maturity and we are actually going through, as a committee, over the next couple of weeks all of the Meaningful Use Workgroup, they Policy Committee's questions using this framework to really take a formal look at a lot of the things we're going to discuss more informally today on the call.

So, I can tell you in general problem list I feel fairly good about reconciliation, because whether they are represented in SNOMED CT which is our preferable vocabulary or historically in ICD-9 map to SNOMED CT, I think there is going to reasonable control over problems so that reconciliation is possible.

Medications, again, you know, I think we've done a fair amount as a country to represent medications in RxNorm and mapping to RxNorm of NDC and commercially available codes like First DataBank, so I feel reasonably good about that. Beth Israel Deaconess already does reconciliation in each transition of care inpatient and outpatient using the Surescripts historical data feed and internal exchange of data, so, I think it's doable. Allergies I think are going to be challenging.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

John Halamka, MD, MS – Harvard Medical School

And allergies and contraindications I think you wisely separated contraindications…Allergies is funny, because of course we today can use vocabularies to represent a substance environmental or food, or medication that you may have an adverse reaction to and, you know, again, we don't all know what Stage 2 says, but let's say that Stage 2 is going to include appropriate single vocabularies for those. What's a little tough is, what is the nature of the reaction, the severity of the reaction, the observer of the reaction? At least my experience when I look at commercial products today is everyone represents the metadata around an adverse reaction differently. So, I do have concerns about that one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, John, this is Paul Tang, sorry, I joined late. Is there any work going on to standardize the reaction type?

John Halamka, MD, MS – Harvard Medical School

Let me ask Jamie and Betsy if they are specifically…they're working, as you know, on this National Library of Medicine Nationally Curated Vocabulary and Code Set Project.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

John Halamka, MD, MS – Harvard Medical School

And certainly I know that in there is the medications you are allergic to or have an adverse reaction to, the foods and the environmental substances, but as to the severity or the nature of the reaction I'm not sure, so I'll ask.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And that of course could fit into the contraindications.

John Halamka, MD, MS – Harvard Medical School

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We'd love to have a set of reactions including intolerances that we could apply both to medications as well as to procedures.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And, it would be great if this really was a general framework that, you know, in another 2 years when someone says, oh and there is this other type of reaction, that we typically you don't think of as a contraindication or a medication allergy, that we're not getting hung up on the clinical finesse, you know, fine points, but we're actually addressing sort of the underlying structure, because the things you've described, John, structurally, you know, there is an agent that you have some reaction to, what's the reaction and how severe is it, and maybe some of the documentation around how do we know this happened.

John Halamka, MD, MS – Harvard Medical School

Right, so, an example…

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

…structural pieces.

John Halamka, MD, MS – Harvard Medical School

When you look into a commercial product that I have actually my record in it says, allergy to penicillin, now is that my mom saw a bump on my stomach when I was 2 or I anaphylaxed in the hospital the last time I was given it?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

John Halamka, MD, MS – Harvard Medical School

That's the problem.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And, you know, I think the testimony we heard in one of our public hearings that was really focused on patient generated data, I suspect that one of the reasons that the patient was having problems communicating with the clinicians is they didn't have it in their records so they didn't know at what level of severity he was describing his reaction.

John Halamka, MD, MS – Harvard Medical School

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

You would think if he had been able to convince them of the prior documentation they would have acted differently.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, John, your advice to us sounds like to say, postpone allergy reactions and contraindications to Stage 4 and the ask is that the industry develop/agree on value sets for the nature of reactions?

John Halamka, MD, MS – Harvard Medical School

That would be a very good summary of my best thinking at the moment and Paul what I said to the group earlier is I actually, based on the e-mail you sent me on Wednesday, the entire Standards Committee, I actually have assigned to three workgroups, Implementation Workgroup, Clinical Operations, Vocabulary Taskforce Quality will be formally responding to each of the questions that you asked using a framework we adopted yesterday in the Standards Committee meeting for standards maturity. So, I think what you've summarized is perfect for everything I understand today of getting even more formal feedback.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And you think…

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, a question about this, do you feel like we could move ahead with medication allergy reconciliation even though we don't have the additional coding?

John Halamka, MD, MS – Harvard Medical School

Well, so, I worry that if you just simply say penicillin, oranges and house mites without all the rest that I'm not certain that reconciliation would be that clinically helpful. And, you know, can certainly ask Jamie and Betsy Humphreys if through the work they're doing with SNOMED and LOINC if they feel like at least, for certain aspects of medications, that they're going to have a code set sooner rather than later.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah, because I don't want us to get hung up in perfect becoming then enemy of the good, on the other hand, I don't want not really good enough blocking further progress.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

John Halamka, MD, MS – Harvard Medical School

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, John, I think the kind…I know this is one of them that is a potential for…allergy…medication allergies for the certification process for vendors and I certainly understand the kind of things that we're going through, which is important right now as we're trying to figure this out, there is a ton of work going on in HL7 in this space, it's the difference between ingredients and then the medications, because sometimes they don't reconcile, but again, those are important things to like get our arms around sooner rather than later because, again, those are some gaps in the current standards.

So, that would be again an important piece to understand, because sometimes like, you know, you're allergic to Tylenol or it's an aspect of Tylenol that you're, you know, allergic to or whatever and that…again, we don't know how severe it is, but maybe if you guys could look at that framework you could come back and say, we should put it there for viewing purposes, you know, you could give us some advice in terms of how to move forward in that.

MacKenzie Robertson – Office of the National Coordinator

Hey, everyone, this is MacKenzie, sorry I just wanted to make one clarifying point from John's recap of the Standards Committee meeting yesterday. It wasn't all of the questions that were sent to the Standards Committee for comment, I believe it was just a selection of the meaningful use questions that were sent over and we're going to be meeting on Friday to determine which of…there are actually four workgroups that were tasked to look at them, the Clinical Operations Workgroup, Vocabulary Taskforce, Clinical Quality and the Implementation Workgroup. So, we'll be meeting tomorrow to talk about which workgroups will be looking at which questions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And, John, what do you think the turn-around-time do you think would…

John Halamka, MD, MS – Harvard Medical School

Well, miraculously the deadline of September 12th was given, so we will get it to you before your deadline.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Super, thank you.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, Paul, how do you want me to leave this one? Just leave it as the question you framed?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, no, I think, I mean his recommendation, unless the workgroup comes back otherwise, the other workgroups come back otherwise, is that we hold allergy and contraindications for Stage 4 and have a specific.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Framework?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, have a specific ask back to the HIT Standards Committee who can make recommendations to, I guess standards development and ONC, about the need for a value set for nature of reaction.

Michelle Nelson – Office of the National Coordinator

Yeah, so just to clarify, this is Michelle, this one was not included in the list that was sent over to the Standards Committee. So, I think that we need to include a question in this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah. Can you chase it with…?

Michelle Nelson – Office of the National Coordinator

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And the other piece of this one, and I think I would ask in terms of that piece, is because as you look at some of the…there is also then some of the contraindications that become problems. So, that whole space kind of needs to be looked at so they are not overlapping if you will. So, as you detect, you know, contraindications those emerge as problems sometimes and then they get overlapped there. So…

John Halamka, MD, MS – Harvard Medical School

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, we do that because we don't have a place to put them and we want in front of people's face.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, as EHR vendors think about "contraindications" they need to have a way that it is in front of us just like medication allergy is.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, but they link together is all I'm saying, so…

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I guess I want to push back on the medication allergies piece for Stage 4 versus Stage 3 and…so, here's the model I've got for why I think it would be useful earlier, but I understand it could also be a huge burden on the providers. So, I've seen some pretty nice demos of this is a CCD and we've taken apart the components and now we're going to do a reconciliation process.

So we show you what's in the CCD and then we let you click on that thing that, you know, let's say this is an allergy and now we're going through a process that's both manual and automated of converting it from what you're reviewing coming in as a piece of history or information from another provider and we're asking you in our EHR, in the native EHR that the clinician is using, to go through a human process of assessing do you want to bring this forward into your record and if you do we'll take you through a coding cycle so we code it consistent with how our EHR is working.

And depending on the goodness or the badness of the automation there it could be a lot of work for the clinician or it could be as simple as check, check open and bring these in.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I guess I'm putting that out for discussion because as someone trying to encourage putting more information into our care summaries and shipping them between providers I've been arguing that a list, even if it's just text, is better than no list. And the reconciliation process even if its manual is better than no reconciliation, but I'm open for being informed about the burden I might be putting on providers, because the coding isn't there to make it fast and efficient.

John Halamka, MD, MS – Harvard Medical School

Right, so here's an example for you, for those who used Google Health, when it was alive and well, Beth Israel Deaconess was one the early data testers and we submitted all of our allergy information including severity, observer, you know, reaction time all that stuff to Google Health and Google Health decided that an allergy should be represented as substance, you know, good or bad reaction, it was a binary thing, you know, and that was all. And so, there was no mapping that would allow a reconciliation between our system and their system because they had chosen to represent the nature of the reaction using a different code set than we had.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And then, I'll give another, so of the things that we capture in each provider's record, paper or otherwise, allergies actually is one of the things that is most complete, in fact it is even based on a review of the charts, that one, people do because they recognize the importance to do this already and it's done by essentially reconciling with the patient.

So, to create additional functionality, you've described additional functionality which does not exist almost anywhere, and the burden of saying that you've got to have a check off measure, that is something where the problem is not there to fix at the moment. So, we want to have what you described but we cannot have all the unintended consequences that John just described of systems that try to operate in a brand new functionality without standards. So, I think you would cause a lot more burden without a lot of good, because it's done conscientiously right now by humans.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, remind me, allergies is in the Stage 1 Meaningful Use definition for CCD, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But they're not standardized.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, I understand, so we're going to be shifting them, but we're not going to be creating a reconciliation mechanism, we're not requiring it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is not an efficient nor an accurate way of doing that and it so happens that people do this human process fairly well because its…one, it's fairly stable, you don't increase your allergies all that much.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, everybody gets it at intake and they maintain it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's not the…the gap of the problem is not there.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So there's more gap in the medication list and more gap in the problem list.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, absolutely.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Mostly because they're more dynamic, okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well, I would, you know, if I go back to my parsimony hat it's probably better to focus on getting a few things right than trying to get a lot of things going. So, if we've got problems reconciled and medications reconciled it sounds like we'd be making big steps in the right direction.

John Halamka, MD, MS – Harvard Medical School

Sounds good to me.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so I think we're back to then, John, making the recommendation that reconciliation of medication allergies and contraindication need this framework that we've described and that request then needs to go to the Standards Committee.

John Halamka, MD, MS – Harvard Medical School

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And right now it would be a placeholder for Stage 4 would be the recommendation unless you come back with a different answer based on your research.

John Halamka, MD, MS – Harvard Medical School

Yes, good.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. Again, I'm a little sensitive to time, but Larry had asked us to make sure that we check mark all of those other objectives, which I don't have in front of me, but Larry, are you comfortable this one achieves our guiding principles?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Let me take a quick look.

Michelle Nelson – Office of the National Coordinator

Do you want me to read them off?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Model of care priorities…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Generally, the big one is…this is the one, you know, that scalability across practice, across specialty, as well as across location.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, my take is that we're doing this and it's probably worth emphasizing when we present this back, assuming we will be presenting this back, our notion of focusing on some coded, achievable, high value things to reconcile and looking to extend that to other areas in Stage 4.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, I'm good.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, next slide, please. Okay, this next one, again is the advancement of using…for those people who transition care record to provide the care record summary, and again, what we did for Stage 3 was to continue to use the concept of the consolidated CDA, and again in Stage 3 what we wanted to do was to begin to really set the class forum for care coordination, so, we called out a couple of key pieces of information, again that we felt needed to be required and potentially coded if possible in Stage 3. And again, we're sensitive to things being both in free text as in standards and we called those out.

The question was raised relative to could there be a different kind of measurement process, if in Stage 2 would we for instance be able to know the people based on having a network of, you know, an NwHIN set up and potentially know who were Meaningful Users and not Meaningful Users that we could use a different measurement system for instance relative to setting our thresholds, i.e., if you had a Meaningful User at the other end you had to have a higher level of performance electronically than a Non-Meaningful Use User. So, is there a different way to potentially, you know, create, you know, our objectives by Stage 3? So, I'll kind of, John, let you comment on that and I also have some feedback that I gathered on that.

John Halamka, MD, MS – Harvard Medical School

Well, so in the State of Massachusetts as we go forward with our state-wide health information exchange goes live October 15th of this year, we are in our provider directory actually marking the technical capabilities of each recipient which will be used in the transmission process to insure appropriate delivery for their technical capabilities on the receiving end. So, you know, as a funny answer to your question is, well Massachusetts may be able, because of its building of a centralized infrastructure have some capacity to measure what you've just said, but I worry that most locations won't have the capacity to even understand the technical capabilities of the end-point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, now I think Charlene was referring just to whether you are an MU qualified provider not necessarily…I mean, it's preferable to do what you are doing in Massachusetts knowing how capable you are of exchanging health information, right now it's just to narrow the space and saying, instead of figuring out what's the magic number of all providers out there who, you know, what's the magic threshold for you transmitting summary of care documents electronically and trying to get some kind of country norm when actually the more relevant set is who at least has the information electronically and through certification criteria should be able to accept this but that doesn't spell out the whole domain, but at least narrow your denominator to a more reasonable set, that was sort of the game plan.

John Halamka, MD, MS – Harvard Medical School

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It would be nice if we had what you have, essentially a registry of capability throughout the whole country, maybe that's where it will go.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

John Halamka, MD, MS – Harvard Medical School

Yeah, I just worry that if I am a Meaningful User how would I know whether the person on the receiving end is capable of receiving my electronic transmission? I guess when I attest how would I even know that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, you can look it up on the web.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, John, this is I guess an operational question, but we've been making the assumption that providers would be building up their own directory…in the same way that we're asking patients how they want to receive information, that they would be working with their various partners on how they want to receive information, is that an unreasonable expectation?

John Halamka, MD, MS – Harvard Medical School

Well, I guess the operational issue is the way we are looking at health information exchange often is I throw something over the transmitter to our local HISP, the HISP then delivers it to a recipient in whatever means that recipient can receive, it could be secure e-mail, it could be fax, it could be, you know, Direct, we don't know. So, I am not sure that that local directory would actually include metadata about the nature of what the recipient can accept, that would be my operational concern.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, what you're saying is someone needs to know that but it may not be the provider?

John Halamka, MD, MS – Harvard Medical School

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And I asked this one to the vendor community, I actually solicited comments and again that was pretty consistent was, they were pretty concerned about knowing, figuring out how to know and felt that might be a bit of a nightmare. And their other comment, again, and they said that today the infrastructures are already built to be able to account for things in the way that we asked for the measure, and again that should not be the barrier that they've got to recode everything, the bigger barrier was the challenge in being able to do it, but they also said in the marketplace people are getting trained to actually do things in the way that we specified the measure and they felt it might be an easier path forward.

John Halamka, MD, MS – Harvard Medical School

So, to summarize then your recommendation that…how would you compute the numerators and denominators for this?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Again, the care record…the provider themself is going to count, know somehow and hopefully it's going to be on base on the concept of a transition order that a transition occurred and for those be accountable for 65% of the transitions sending something and 30% electronically. So, again, if they would still have to have some knowledge, especially if it went to, you know, a centralized facility to whom you sent it electronically for, but in some cases they have to know that today.

John Halamka, MD, MS – Harvard Medical School

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

What would not be measured on would to know that, you know, if they sent it to this many Meaningful Use Users that they sent it electronically 80% of the time. So, that would not be part of the criteria.

John Halamka, MD, MS – Harvard Medical School

So, I like the wording that you had just restated because I throw it to the HISP 30% of the time and whether the person on the receiving end is a Meaningful User or not, I mean, I sent it electronically, I did what I was supposed to. So, I think it's a much more controllable thing to use the language that you just described, not discriminating between who is a Meaningful User and not.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, do we want to…because you're right, John, we want to encourage people to do the same and the theory is that if there are enough senders out there it becomes a value to a receiver as well.

John Halamka, MD, MS – Harvard Medical School

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, now 30% may be high if you want to take all commerce then, right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well you're no longer distinguishing; you're saying whenever you have a transition sent electronically it's not your problem if they can't receive it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, but not everybody has an intermediary available to them, so the burden…I mean it's one thing…John can go ahead and just send it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It is a stretch, Paul, it's, you know, it is…you know, we'll have, you know…

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well it just seems like too big a stretch.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, I don't…

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

…the whole country.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, are we better off talking, since we want to talk floors and not ceilings, are we better off dropping the percent?

Michelle Nelson – Office of the National Coordinator

This is Michelle; I just will emphasize Steve's point that we should worry less about what the percentages are and just kind of give some guidance on…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Direction?

Michelle Nelson – Office of the National Coordinator

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, the…and, you know, we thought about some categories, one of its categories was introductory. In the past we have used 10% as introductory, but, you know, 30% seems more than introductory. So, categorically it would be nice to say "wow, you're just starting this, how do you…" We can translate our 10% into introductory and 30% like advance or something.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, Paul, I don't remember now how much of this was in Stage 2.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I don't either.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

None, none electronically.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
There was no electronic requirement just that you produce a summary?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You were allowed to print everything.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, printing was accepted.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I thought we were moving beyond just testing CCD exchange on Stage 2?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, actually Stage 2, Michelle do you have that?

Michelle Nelson – Office of the National Coordinator
The percentage isn't in the NPRM side, I'm not sure why. I do believe it was a two-part measure in the NPRM and I can't remember percentages because it's getting closer to the final.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yeah, if anything it was 10%.

Michelle Nelson – Office of the National Coordinator
Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If there was a percent stated.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Yeah, and so, Paul, we kind of made the assumption we'd be at the next tier kind of…

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I see.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
In Stage 3 that's all, because…

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Again, I think we can be open to that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
You know, that was why we bumped it a little bit higher.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Got it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

For Stage 3.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, maybe in our commentary we need to note that we're going to review this in the context of Stage 2, because over the next month or so there is an expectation those will be public, that we will have final rules published.

Emma Potter – Office of the National Coordinator

This is Emma, sorry, are we referring to objective 3 of 3 and were wondering what the measure was as far as percentages go for the Stage 2 NPRM?

Michelle Nelson – Office of the National Coordinator

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Emma Potter – Office of the National Coordinator

So, according to the matrix it was provide a summary of care record for 65% of transitions and then the second measure was electronically 10%.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Michelle Nelson – Office of the National Coordinator

But, it will still loop back with the Stage 2 final because those percentages could change.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. So, what we're saying is there is a piece in Stage 2 that's going to look for electronic and look to measure it and we'll see what wound up in the Stage 2 rule, and then we want to raise the bar in Stage 3.

John Halamka, MD, MS – Harvard Medical School

And it sounds good, generally, but it will be fascinating knowing the discrepancy among health information exchange capabilities and our various reach and what is going to really be achievable in practice.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, well, you know and I'm sure there will be an exclusion if you don't have local capability to send, right?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, John, logically, if there was some way to understand…like, you know, a model that said, here's your interoperability capability and if you've got a model that's an A you're at this level and if you've got a model that's a B, and I know this sounds way too simple, we could change our model eventually. So, again, we're the ground, so if we have to lower it we'll lower it. So, I think that's well said, but it would be nice over time to have something that we could map into.

John Halamka, MD, MS – Harvard Medical School

Right, so, I mean, for the moment I think keeping it simple, as you suggested and play with the percentage, but as centralized registries HISPs and provider directory standards get further developed then there is the potential for a dual level measure as you say.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And, John, assuming some of this shows up on the work that standards is doing, any guidance around where provider directories are would certainly be helpful in general.

John Halamka, MD, MS – Harvard Medical School

Right, because provider directory S&I Framework activity actually ceased, you know, the provider directory stuff is very much a work in process and, hey the Massachusetts provider directory goes live in just about 60 days, I'll let you know how it goes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we're anxious to find out. Okay, other comments on this slide? Okay, next slide. Okay, there are two measures here and we've got about 15 minutes left. One, is again we did a lot of work to try and think through the need to create a model that started to create the basis for more collaborative care and we recognized there is a potential infrastructure that exist beyond EHRs that actually tracks that venue view whether it's an HIE or some mechanism, but what was important in Stage 3 was to be able to feed that information relative to care plan and we narrowed it, because we said you don't need this in all cases, but where it's critically important is in site transitions of care.

And, again, Larry's on the team representing long-term post acute care and we said there are some key information that's important. So, we tried to make this as a concept where we started to get our arms around that information that is needed to be shared for care planning purposes in a more patient centric view and assuming that each venue, again has pretty sophisticated care planning capability, but at transition then would provide a subset of that information that would be shared either between sites and/or with a platform, and again, we know that doesn't exist, but we're trying not to go there way too soon.

So, that's what these elements list and again, I think you mentioned, John, the tension between what's free text versus what's standardized and again, the potential and some of the feedback I get here is that too much information isn't going to be helpful either and the vendors are going to be challenged to try and make it look as crisp as possible and you can't make it look crisp if you don't know what it is. So, again there is some balancing that needs to go on here. So, again, we'd appreciate your input on this.

John Halamka, MD, MS – Harvard Medical School

Right, so I think, MacKenzie, did you send around the document that I had forwarded from Larry Garber?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

No, I did not.

John Halamka, MD, MS – Harvard Medical School

Okay, because he had…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Larry did testify for us and Leslie Kelly Hall has been working, as well as Eva, pretty closely on that team so they listed it, so we might have got some information…it could have got lost in translation and I can share that with the workgroup or, you know, I'll have to see it.

John Halamka, MD, MS – Harvard Medical School

So, I'll resend the e-mail I thought that I had sent to MacKenzie, a summary yesterday, but, basically what Larry Garber has nicely summarized for us all is what is the current state of a consolidate CDA, care plan as balloted by HL7 today.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

John Halamka, MD, MS – Harvard Medical School

Versus what are the ballot planned for January and May of 2013? And so it's a very elegant document and basically what it shows you is that today your care plan is going to be in fact a free-text list of next tasks.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

John Halamka, MD, MS – Harvard Medical School

Whereas, the January and June 2013 ballot is actually now codifying very specific longitudinal care plans, actions, you know, these are things that are going to go beyond the sub free-text, but it's giving us much more structure in a CDA context that could be used for some of the things that you highlighted in the wish list, the aspiration that you sent me.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Aspiration list, yes.

John Halamka, MD, MS – Harvard Medical School

So, for now, you're right, free-text blob, June 2013 much more structured.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You said June or January?

John Halamka, MD, MS – Harvard Medical School

Well there are two ballots and I'll send you the detail from Larry Garber where there are sort of three steps, free-text now, combination of free-test and structure January, more fully structured June.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Now that's ballot…what's the time course from ballot to approval to implementation guide? I mean, what's the time horizon for actually being even capable of being put into a commercial system.

John Halamka, MD, MS – Harvard Medical School

Well, so, Charlene, I'd love your feedback on this, but my feedback is generally HL7 ballot to implementation is 18 months.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, I would expect that's the case.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Implementation in product?

John Halamka, MD, MS – Harvard Medical School

In product, yes. I mean, 18 months is sort of the aggressive, you know, it's come out of ballot, it's a fully validated standard with a good implementation guide and now you've got an end product, you know, running 18 months.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The gap we would have here, Paul, is that again, this is really brand new space I think for any new vendor.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, again, if there was a way that this project was similar to Direct or one of those projects where we actually got some ground experience before we rolled it out, that would be really valuable. So, I would be hesitant, if you will, because again, you know, a lot of products don't, especially on the ambulatory side don't have this kind of capability in them yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well there are two things, one, the product doesn't exit, second, the physicians don't know how to deal with this yet.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I'm a bit nervous of saying, you know, if you are aggressive that it could actually make 2016 in real practice and real…two things, in real products, in real practice. So, that seems like you might push us to putting it in Stage 4 so people are starting to understand this. Then the next question is how much text blobs do you want to be moving around.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You may say, yes I want it or you may say…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Paul, the thought that we talked through was should this be something in Stage 3 because most, again we have to test this out, acute care hospitals have care planning capability in them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

For hospitals and then move it broader in Stage 4.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, there is today, in CCD, there is a section for care plan.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It could certainly accommodate a text-blob, so we do have a method to transmit text-blobs within our current framework.

John Halamka, MD, MS – Harvard Medical School

Right and so the ones, I think you guys have stated it very well; I'm actually more concerned about the burden on the workflow and the fact that doctors just don't do this currently and the systems don't really have a place for it than I am the standard for transmitting the result.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I would agree.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, that was the feedback we got from the clinical people that looked at this, is its all great information, but unless I can get it…it's going to be too much information.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I guess what I'm hearing is having it in Stage 4 is directional, puts out there that we really would like to see people pick up the standards that will be emerging so they can build on it and we may have some examples of early users who have figured out how we're going to integrate this into workflow and this is now…I mean, in some ways its extending the reconciliation piece, right? How do you take the information you get from another provider and use it?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I think, I mean, that's a fine plan, we're defining a useful product, finding a pathway to get there and understanding and appreciating the timeline to make it reality but were putting it out on the pathway.

John Halamka, MD, MS – Harvard Medical School

Yeah, sounds good to me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay.

John Halamka, MD, MS – Harvard Medical School

And I will circulate the Larry Garber document for your reference.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, thank you.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so…

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Thanks, looking forward to it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

What our intention though is, is we would…what our intent here though is really to adopt a standard to do this rather than free-text, is that what we're saying?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well, there is already free-text capability.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

If someone wants to use free-text go for it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, but are we going to measure them at that in Stage 3?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, I don't think we are going to, I mean, people have ways of communicating information, but we're trying to establish the pathway to getting it into a much more useable format and allowing both the product…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, I'm in favor of that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I'll put out a wish that I don't know how we move on this, which is we're going to be seeing increased generation in transmission of care summaries, so CCDs are going to start to flow in the world. It would be great if we could get some analytics back on not the clinical analytics, but the, what are people putting into the CCD, which sections are getting filled in, what code sets are they using, how consistently and richly are they coding things, it would be great if we could encourage the HIEs or ONC through some other mechanism to start documenting what's actually being sent. It would be so helpful as we go through these discussions.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, Paul, I've got a question for you. Would we…based on what John just said, would we put in place a certification requirement for Stage 3 some of those standards so they could be used in Stage 4?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I don't think you can make it, can you?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I can't make it yet? Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, I mean, you can put it in if you think people could make it, but if you're using the aggressive timeline…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, it would be aggressive.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, it wouldn't even make it let alone, you know, if it doesn't meet an aggressive…I mean, I think, it's very aggressive to think that in 18 months we would have this.

John Halamka, MD, MS – Harvard Medical School

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

The problem is going to be that if the vendors do it right they may need to modify their care planning halfway.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

They do, they're going to have to.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And that's going to have user ripple, so it's not going to be a trivial enhancement and we don't want to be in a place, you know, in 2 years where people are screaming about my care plans now are mess because you guys changed the technology on me and it doesn't fit with how we do things.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so we're going to move this as a placeholder for Stage 4 but the intention, and this is to John Halamka, is to look for the standards for as that placeholder to be able to do this in Stage 4. Is that what we're agreeing on?

John Halamka, MD, MS – Harvard Medical School

Yeah, and I will…I mean, assuming that HL7 ballots are successful and you get a whole team working on this, it's highly motivated and its aligned with the exact objective that you have, I think it's fair to say that by Stage 4 your standards will be in place and at a level of maturity that adoption is possible.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That's awesome.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think, again, it's important to put that rationale in our commentary, because we're making some assumptions here, we're telling people don't go to sleep, we really want to see adoption here, we think it's really important, but we're trying to not force a pace that doesn't make sense.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That's a huge signal I guess.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And then the last one, I'm just going to move through, we've got 5 minutes, the last one, this was based on some testimony that we got, what we're trying to do in Stage 3 is set the infrastructure for closing the loop on referrals. So, again, we put in place, under sending out orders for referrals and we understand standards exist for this and this is the provision to actually track that a referral is actually provided, the request for the referral is actually provided back, so we can actually close the loop, and again, we know this is start up so we've put it at an entry at 10%, but again, 25% of referrals the loop is never closed on today, that's a pretty big number. So, that's the problem we're trying to solve here.

So, John, I don't know if you can…and the feedback…and I'm forgetting who gave it to us, David Kendrick I think, said the standards pretty much exist for communicating referrals and communicating referral results back. So, I don't know if you can provide us guidance here?

John Halamka, MD, MS – Harvard Medical School

Well, I'd be very interested to what standards he is referring to, whether he is talking about X12, A35, A37 kinds of administrative or the clinical summary or what?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This was actually a referral request and the response, but, you know, this was one of the beacon partner ones and we never got the paper from them so I can't even give it to you.

John Halamka, MD, MS – Harvard Medical School

Right, because I can tell you that in Boston all of the Harvard Hospitals are self insured by a group called CRICO. CRICO has a close the loop on referrals initiative this year and Partners', Beth Israel Deaconess, Children's and Atrius are all inventing the technology this year to make it happen because none of us could find existing technology that would do it. So, hmm, I am unaware of any widely adopted standard to be used for the purposes that you've suggested.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Is this one…?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, John, I guess the question to toss back at you guys is in HL7 2 there are consult reports, formats that could be used, right? And, in V3, in the XML world and the CDA world I think there is also a consult report.

John Halamka, MD, MS – Harvard Medical School

Right, the question I was asking was if in fact you're talking about an X12 kind of message that says, I am now sending you a consultation or a request for consultation and you are now acknowledging it and sending me back and my consultation is finished now, you know, some sort of close the loop transaction as opposed to, oh, here's a text-blob with a consultation I finished, because you're absolutely right, I mean, there is no reason that a CCD couldn't be used today to send back a consultation report.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we're okay with that, if you come back with an approach to this one.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, is this a pending question we have out to one of your workgroups, John?

John Halamka, MD, MS – Harvard Medical School

Hmm, I didn't see it.

Michelle Nelson – Office of the National Coordinator

No, it's not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we need to follow-up, because this is one of our biggest wins for everybody, but we have to make sure we're timing it right.

John Halamka, MD, MS – Harvard Medical School

Yeah, and again, I think it's just a question of, did an electronic summary go back to the individual who requested the referral or something like that, you know, that's doable today, it's…we're really looking at…

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And we were trying to not overly burden this, so we were looking at the consultant having to send it back.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we're just…

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, it wasn't technically closing the loop, the receiver might not actually know that this was the report for a specific referral.

John Halamka, MD, MS – Harvard Medical School

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

If there is a way to make it better that would be great, but we were trying to make it achievable by being simplistic and maybe we're being too simplistic, let us know.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And we kind of assumed that if those systems would start to get smart enough to track when they sent something out and got something back, that would start to be part of the process too, but we didn't prescribe all that.

John Halamka, MD, MS – Harvard Medical School

Got it, yes, so, I guess in summary if all you're doing is asking a consultant to send back a text-blob in a CCD or consolidated CDA sure the standards are fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But wait a minute…no go ahead.

John Halamka, MD, MS – Harvard Medical School

But if what you really want is close the loop, that is a PCP knowing what was ordered and a specialist being held accountable for returning a consult on what was ordered, because that's really closing the loop.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well that what we do want.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, but under the David Bates section there is an order going out for this an we're hoping to close the loop, you know, so there is an order going out and then there is a close the loop coming back.

John Halamka, MD, MS – Harvard Medical School

Right and that's where I don't think the standards really are mature to do.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, right, so we need…

John Halamka, MD, MS – Harvard Medical School

I mean, sending text-blobs back and forth, closing the loop really with transactions need additional work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we want the latter because it's not…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's not useful to the PCP to…I mean, we won't get notices of unclosed loops and we won't get notified of the right material.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

John Halamka, MD, MS – Harvard Medical School

Exactly, and that's what I meant when we in Boston are trying to invent this, it's here's a log of everything you sent and everything you didn't receive, it's really, honestly getting administrators to be able to close the loops that a doctor or patient made and oversight, you know, they would appropriately be notified so that cardiology consult will get done.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, again, I think we'd like to refer this one to you and just get…we'd like to leave this in Stage 3 at this point because we do keep it simple, it just may not end up closing the loop, you know.

John Halamka, MD, MS – Harvard Medical School

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

All right, what you're saying, we might not get fully there but we want to move in this direction.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, then we'd better put that in Stage 4.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well, but we in Stage 3 should be able to at least meet this measure, you know?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the measure says that a return…yeah…

M

They don't have any way to return.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, you're going to have a counting problem here.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, so we have to think about that, but I would definitely put the automated…the literally the resulting the referral order be for Stage 4.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, and that's…the other section, so we've got to come back and look holistically at that, but that's what…the testimony we got was that order function was there, but it could be X12 or some other way that they did it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And they may not have been looking at the actual transactional close the loop, so I think it is at least worth revisiting this so that people can acknowledge that, oh, yeah, yeah, we thought we had a solution maybe we were over simplifying.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so the way you wrote it is referral results, maybe that's the thing that could be vague, the referrals are generated from the EHR returned to the requestor, but in Stage 4 we want it to automatically satisfy the order placed.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, exactly, yes perfect.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Because, you're right, Paul, that then becomes valuable to the clinician if they've got an actual linkage back, it gets in the right chart, they can check off a status, they can know that the thing they are waiting for has come back as opposed to a random thing that shows up.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

John Halamka, MD, MS – Harvard Medical School

Cool.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, are there any other…we're at the actually end of our time because we were closing at 4:00 so I need to open for public comment, but are there any other comments or recommendations? Most of the other items we referred for Stage 4 at this point, these were the primary ones that were our focus for Stage 3, because the net is 3 will remain for Stage 3 and then we'll move…the 3rd one as a candidate to Stage 4 and we'll also move out medication allergies to Stage 4.

John Halamka, MD, MS – Harvard Medical School

Sounds good to me.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, any other comments.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Good discussion today, thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Thank you and John thank you for spending the time with us too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, thanks, John, appreciate it.

John Halamka, MD, MS – Harvard Medical School

Absolutely, yes, have a good day, thank you.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

All right and I'll open for public comment.

MacKenzie Robertson – Office of the National Coordinator

Operator can you please open the lines for public comment?

Public Comment

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, well thank you everyone for your time and Michelle I'll get back to you to try and get all the notes cleaned up if that works, okay?

MacKenzie Robertson – Office of the National Coordinator

Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Or MacKenzie.

MacKenzie Robertson – Office of the National Coordinator

I think Michelle just got disconnected so I'll be sure she hears it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Thanks, guys.

MacKenzie Robertson – Office of the National Coordinator

All right, thanks everybody.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, bye.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Bye.